DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC accepted 12/1/08 mettarell

RECEIVED
NOV 24 2008
BUREAU OF LICENSURE AND CERTIFICATION
CARSON CITY, NEVADA

PRINTED: 10/13/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290027	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVER C DILS MEDICAL CENTER	700 N SPRING ST, BOX 1010-C-ADM BLDG CALIENTE, NV 89008

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare re-certification survey conducted at your facility from September 22, 2008 through September 25, 2008. One complaint was also investigated during the survey. Complaint #NV00012470 was unsubstantiated. The following Conditions of Participations were not met: CFR 482.13: Condition of Participation: Patient's Rights CFR 482.42: Condition of Participation: Infection Control CFR 482.45: Condition of Participation: Organ, Tissue and Eye Procurement The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	A 000	A 000 For the deficiencies cited during this survey, this facility has or will develop and implement a facility-wide system to assure correction and continued compliance with the regulation(s). This facility has/will also provide a complete copy of this deficiency list to our Quality Initiative and Compliance Committee for review and/or appropriate action(s). This plan of correction is being submitted pursuant to the applicable federal and state regulations. Nothing contained herein shall be construed as an admission that the facility violated any federal or state regulation or failed to follow any applicable standard of care.	
A 047	482.12(a)(3) MEDICAL STAFF - BYLAWS [The governing body must] assure that the medical staff has bylaws. This STANDARD is not met as evidenced by: Based on interview and review of available documentation, it was determined that the governing body did not assure that the medical staff had current bylaws that reflected the	A 047	A047 Medical Staff Bylaws will be reviewed, updated and approved by the governing board. The governing board will approve Medical Staff Bylaws as needed and during the first Board of Trustees Meeting of the fiscal year. The review and approval of Medical Staff Bylaws will be set as a re-occurring agenda item. The Administrator will be responsible for monitoring and assuring the scheduling this action.	11-4-08

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jason Black | Administrator/CEO | 20 Nov. 2008

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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A 047	Continued From page 1 Medicare conditions of participation. Findings include: Review of the Medical Staff bylaws provided by the administrator on 9/24/08 revealed they had not been updated since 9/15/98. The medical staff bylaws were not signed by the current governing body or the current chief of the medical staff. The bylaws did not reflect current practices or procedures that were being done by the medical staff. For example the bylaws stated that review was being done of the infection control surveillance information. This was not being done. (see Tag 0749). Interview with the administrator on 9/24/08 confirmed that this was the only set of bylaws and they had not been updated since that 9/15/98.	A 047		
A 048	482.12(a)(4) MEDICAL STAFF - BYLAWS AND RULES [The governing body must] approve medical staff bylaws and other medical staff rules and regulations. This STANDARD is not met as evidenced by: Based on interview and documentation review, it was determined that the facility's governing body failed to approve the medical staff bylaws and other medial staff rules and regulations. Findings include: Review of the Medical Staff bylaws provided by the administrator on 9/24/08 revealed they had not been updated since 9/15/98. The medical staff bylaws were not signed by the current governing body or the current chief of the medical	A 048	A048 Medical Staff Bylaws will be reviewed, updated and approved by the governing board. The governing board will approve Medical Staff Bylaws as needed and during the first Board of Trustees Meeting of the fiscal year. The review and approval of Medical Staff Bylaws will be set as a re-occurring agenda item. The Administrator will be responsible for monitoring and assuring the scheduling this action.	11-4-08

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A 048	Continued From page 2 staff. The bylaws did not reflect current practices or procedures that were being done by the medical staff. For example the bylaws stated that review was being done of the infection control surveillance information. This was not being done. (see Tag 0749). Interview with the administrator on 9/24/08 confirmed that this was the only set of bylaws and they had not been updated since that 9/15/98.	A 048	A115 The hospital will protect and promote each patient's rights by: A118, A119, A120, A121, 123-- The facility Grievance Policy and procedure will be updated and revised. It will be added to the Patient Admission Packet to ensure that each patient will be notified of his or her rights. The Director of Business Services is responsible for monitoring and assuring compliance to this regulation.	11-14-08
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on interview and documentation review, it was determined that the facility failed to protect and promote each patient's rights. Findings include: Interview with the assistant administrator, charge nurses, and medical physician and documentation review revealed that the following processes were not in place: CFR 482.13(a)(2) (A118) Patients were not being notified of their ability to file grievances and no process in place to address grievances. CFR 482.13(a)(2) (A119) Patients were not being notified of their ability to file grievances and no process in place to address grievances. CFR 482.13(a)(2) (A120) Patients were not being notified of ability to file grievances and no process in place to address grievances. CFR 482.13(a)(2)(i) (A121) Patients were not being notified of their ability to file grievances and no process in place to address grievances. CFR 482.13 (a)(2)(iii) (A123)Patients were not	A 115	A194, A196, A199, A200, A201, A202, A204, A205, A208-- The facility Restraint and Seclusion Policy and Procedure will be updated and revised. Orientation and training will be provided to each nurse and provider. This training will be included in new employee orientation and repeated annually. Documentation will be kept by the Director of Human Resources. The Director of Nursing is responsible to monitor by performing monthly audits and assure continued compliance. Data collected will be presented during the regularly scheduled QI / Compliance Committee Meetings. (See Attachment #1) A206-- CPR training and certification is provided and will continue to be provided to direct care staff. First Aid training specific to restraint use will be provided for direct care staff.	

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A 115	Continued From page 3 being notified of their ability to file grievances and no process in place to address grievances. CFR 482.13(f) (A194) No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f) (1) (A196) No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f)(2) (A199) No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f)(2)(ii) (A200) No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f)(2)(iii) (A201)No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f)(2)(iv) (A202)No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f)(2)(v) (A204)No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f)(2)(vi) (A205)No orientation and reoccurring training being provided on restraints and seclusion. CFR 482.13(f)(2)(vii) (A206) No current first aide and cardiopulmonary resuscitation training, including required periodic recertification being provided to staff. CFR 482.13(f)(3)(A207) No trainer for restraints with the required education, training and experience. CFR 482.13(f)(4)((A208)No documentation of competency in the employees files for restraint training as it relates to the acute hospital setting. CFR 482.13(g) (A214) Seclusion and Restraint No current policy /procedure for the Death reporting requirements.	A 115	CPR and First Aid training and recertification will be provided on an annual or bi-annual basis or as required by policy or certification. The Director of Nursing is responsible to monitor and assure compliance. A207-- Training for the restraints will be performed by a qualified trainer. The Director of Nursing is responsible to monitor and assure compliance to this regulation. A214-- The facility will update and revise the Restraint and Seclusion Policy to include a procedure of reporting deaths to the CMS Regional Office in a timely fashion.(CMS Regional Office contact information is in the policy) This will be the responsibility of the Administrator. The Administrator will monitor and assure continued compliance.	

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A 118	482.13(a)(2) PATIENT RIGHTS: GRIEVANCES The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. This STANDARD is not met as evidenced by: Based on interview and review of available documentation, it was determined that the facility failed to establish and implement a process to file grievances and to notify patients of their right to file a grievance. Findings include: Review of the admission packet and the "Patient's Rights" form that was presented in the admission packet to all acute patients or their legal representatives revealed that it did not identify to the patient the right to file a grievance. When the admission coordinator was interviewed on 9/23/08 regarding the lack of notifying the patients of their right to file a grievance, she was unaware of any process in place. Interview with the administrator on 9/24/08 revealed that the administrator was unaware of a process for patients or their legal representative to file a grievance. Review of the acute care policies and procedures manual provided evidence of a policy for "Patient Complaints and Grievances". There was also a "PATIENT COMPLAINTS AND GRIEVANCE" form that the patients could fill out to identify the "Nature of the Grievance". Per interview with the admission coordinator, the administrator and the Director of Nursing were not aware the policy existed.	A 118	A118 The facility Grievance Policy and Procedure will be updated and revised. It will be added to the Patient Admission Packet to ensure that each patient will be notified of his or her rights to the grievance process. In-services will be provided to instruct admitting personnel of the policy and procedure. Monthly chart audits will be directed by the Director of Business Services. The Director of Business Services is responsible for monitoring and assuring compliance. (See Attachment #2)	11-4-08
A 119	482.13(a)(2) PATIENT RIGHTS: REVIEW OF	A 119		

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A 119	Continued From page 5 GRIEVANCES [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance.] The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee. This STANDARD is not met as evidenced by: Based on interview and review of available documentation, it was determined that the facility's governing body failed to establish and implement a process to file grievances and failed to establish a process to resolve grievances. Findings include: Review of the admission packet and the "Patient's Rights" form that was presented in the admission packet to all acute patients or their legal representatives, revealed that it did not identify to the patient the right to file a grievance. When the admission coordinator was interviewed on 9/23/08 regarding the lack of notifying the patients of their right to file a grievance, she was unaware of any process in place. Interview with the administrator on 9/24/08 revealed that the administrator was unaware of a process for patients or their legal representative to file a grievance. Review of the acute care policies and procedures manual provided evidence of a policy for "Patient Complaints and Grievances". There was also a "PATIENT COMPLAINTS AND GRIEVANCE"	A 119	A119 The facility Grievance Policy and Procedure will be updated and revised. The governing body will delegate the responsibility to review and resolve complaints to the Executive Committee, which will include the facility Risk Manager. Monthly updates will be provided to the governing board during regular board meetings. The Administrator is responsible to monitor and assure compliance to this regulation.	11-4-08

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A 119	Continued From page 6 form that the patients could fill out to identify the "Nature of the Grievance". Per interview the admission coordinator, the administrator and the Director of Nursing were not aware the policy existed. There was no evidence that the governing body had approved the policy or was aware of the process.	A 119		
A 120	482.13(a)(2) PATIENT RIGHTS: TIMELY REFERRAL OF GRIEVANCES [The hospital must establish a process for prompt resolution of patient grievances and must inform each patient whom to contact to file a grievance. The hospital's governing body must approve and be responsible for the effective operation of the grievance process, and must review and resolve grievances, unless it delegates the responsibility in writing to a grievance committee.] The grievance process must include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the appropriate Utilization and Quality Control Quality Improvement Organization. At a minimum: This STANDARD is not met as evidenced by: Based on interview and review of available documentation, it was determined that the facility failed to establish and implement a process to file grievances and to notify patients of their right to file a grievance and include a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the Nevada's quality improvement organization. Findings include: Review of the admission packet and the "Patient's Rights" form that was presented in the admission packet to all acute patients or their legal	A 120	A120 The facility Grievance Policy and Procedure will be updated and revised. As part of the policy, a mechanism for timely reporting of patient concerns regarding quality of care, specifically abuse, neglect or premature discharge to the appropriate Quality Control Quality Improvement Organization. Monthly audits will be performed by the Administrator to assure continued compliance.	11-4-08

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A 120	Continued From page 7 representatives revealed that it did not identify to the patient the right to file a grievance. When the admission coordinator was interviewed on 9/23/08 regarding the lack of notifying the patients of their right to file a grievance, she was unaware of any process in place. Interview with the administrator on 9/24/08 revealed that the administrator was unaware of a process for patients or their legal representative to file a grievance. Review of the acute care policies and procedures manual provided evidence of a policy for "Patient Complaints and Grievances". There was also a "PATIENT COMPLAINTS AND GRIEVANCE" form that the patients could fill out to identify the "Nature of the Grievance". Per interview with the admission coordinator, the administrator and the Director of Nursing, they were not aware the policy existed. The policy also did not include a mechanism for timely referral of patients' concerns regarding quality of care or premature discharge to the quality improvement organization.	A 120		
A 121	482.13(a)(2)(i) PATIENT RIGHTS: GRIEVANCE PROCEDURES [At a minimum:] The hospital must establish a clearly explained procedure for the submission of a patient's written or verbal grievance to the hospital. This STANDARD is not met as evidenced by: Based on interview and review of available documentation, it was determined that the facility failed to establish and implement a process to file grievances and to notify patients of their right to file a grievance.	A 121	A121 The facility Grievance Policy and procedure will be updated and revised. It will be added to the Patient Admission Packet to ensure that each patient will be notified of his or her rights. Included will be a template form to assist the patient in explaining their complaint. The Director of Business Services direct monthly chart audits to monitor and assure compliance.	11-4-08

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A 121	Continued From page 8 Findings include: Review of the admission packet and the "Patient's Rights" form that was presented in the admission packet to all acute patients or their legal representatives, revealed that it did not identify to the patients or their representatives the right to file a grievance. When the admission coordinator was interviewed on 9/23/08 regarding the lack of notifying the patients of their right to file a grievance, she was unaware of any process in place. Interview with the administrator on 9/24/08 revealed that the administrator was unaware of a process for patients or their legal representative to file a grievance. Review of the acute care policies and procedures manual provided evidence of a policy for "Patient Complaints and Grievances".. There was also a "PATIENT COMPLAINTS AND GRIEVANCE" form that the patients could fill out to identify the "Nature of the Grievance". Per interview with the admission coordinator, the administrator and the Director of Nursing, they were not aware the policy existed.	A 121		
A 123	482.13(a)(2)(iii) PATIENT RIGHTS: NOTICE OF GRIEVANCE DECISION At a minimum: In its resolution of the grievance, the hospital must provide the patient with written notice of its decision that contains the name of the hospital contact person, the steps taken on behalf of the patient to investigate the grievance, the results of the grievance process, and the date of completion.	A 123	A123 The facility Grievance Policy and procedure will be updated and revised. It will be added to the Patient Admission Packet to ensure that each patient will be notified of his or her rights. As part of the policy and procedure, a standard reporting form will be prepared for the patient to explain the facility decision. The form will include the name of the hospital, contact person, the steps taken on behalf of the patient, the results of the grievance process and the date of completion. The Administrator is responsible monitor and assure compliance.	11-4-08

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A 194	Continued From page 10 implementation of restraint or seclusion by trained staff. This STANDARD is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to provide direct care staff and the medical staff with current training on the use of physical restraints in orientation and on a reoccurring basis. Findings include: Interview with the charge nurse on 9/23/08 regarding the use of restraints revealed that she had worked at the facility for a number of years. When asked about the use of restraints she stated that they did not use restraints on the acute floor but occasionally restraints had been utilized in the Emergency Room to protect the patient or staff. However she did agreed that there may come a time when a restraint may be utilized on the acute floor for the same reason. When asked about training on restraints she stated she had attended training for restraint use in the past. Further questioning revealed that this training was directed at the use of restraints in the distinct part skilled nursing unit. No recent training had been provided by the facility to the direct care staff on the use of restraints. Interview with the medical director revealed that he had not been provided by the hospital staff the updated information on the use of restraints and seclusion in the acute hospital setting. He agreed that there may be a time that a patient would need to be restrained to protect the patient or staff from harm.	A 194	A194 The facility will ensure the patient's right to safe implementation of restraint and seclusion by trained staff. Each nurse and medical staff will be trained during employee orientation and on an annual basis regarding the safe implementation of restraints and seclusion. The Director of Nurses will maintain a list of those that have and have not completed the training. The Director of Nursing will be responsible for monitoring and assuring compliance.	11-14-08

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A 194	Continued From page 11 Interview with the director of nurses revealed that he was not aware of the reporting requirements for death in restraints. He confirmed that there had been no current training on restraints usage for the acute hospital. He was unaware of what the acute hospital's policy stated regarding the use of restraints. Review of the hospital's policy revealed the components of an accurate policy except for the reporting of death in restraints to CMS and when it should be implemented. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 194		
A 196	482.13(f)(1) PATIENT RIGHTS: RESTRAINT OR SECLUSION Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion- (i) Before performing any of the actions specified in this paragraph; (ii) As part of orientation; and (iii) Subsequently on a periodic basis consistent with hospital policy. This STANDARD is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to provide	A 196	A196 The facility will ensure the patient's right to safe implementation of restraint and seclusion by trained staff. Each nurse and medical staff will be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment and providing care for a patient in restraint or seclusion. A) before performing any of the actions specified in this paragraph, B) as part of orientation, C) subsequently on a periodic basis consistent with hospital policy. Training will be given during employee orientation and on an annual basis regarding the safe implementation of restraints and seclusion. Each must demonstrate competency on an annual basis of this implemented training. Competencies will we kept by the Director of Human Resources. The Director of Nursing and the Director of Human Resources will monitor and assure compliance.	11-14-08

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	290027	A. BUILDING _____ B. WING _____	09/25/2008

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GROVER C DILS MEDICAL CENTER	700 N SPRING ST, BOX 1010-C-ADM BLDG CALIENTE, NV 89008

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A 196	Continued From page 13 the acute hospital's policy stated regarding the use of restraints. Review of the hospital's policy revealed the components of an accurate policy except for the reporting of death in restraints to CMS and when it should be implemented. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 196		
A 199	482.13(f)(2) PATIENT RIGHTS: RESTRAINT OR SECLUSION Training content. The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following: (i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion. This STANDARD is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to provide direct care staff and the medical staff with current training on the use of physical restraints in orientation and on a reoccurring basis on techniques to identify staff and patient behaviors, events and environmental factors that may trigger	A 199	A199 The facility will ensure the patient's right to safe implementation of restraint and seclusion by trained staff. Each nurse and medical staff will be trained during employee orientation and on an annual basis regarding the safe implementation of restraints and seclusion. Training will include techniques to identify triggering circumstances that require the use of restraint or seclusion. The Director of Nursing will monitor and oversee training to ensure compliance.	11-14-08

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A 199	Continued From page 15 Review of the hospital's policy revealed the components of an accurate policy except for the reporting of death in restraints to CMS and when it should be implemented and techniques to identify staff and patient behaviors, events and environmental factors that may trigger circumstances that require the use of a restraint or seclusion. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 199		
A 200	482.13(f)(2)(ii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (ii) The use of nonphysical intervention skills. This STANDARD is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to provide direct care staff and the medical staff with current training on the use of physical restraints in orientation and on a reoccurring basis regarding the use of nonphysical intervention skills. Findings include:	A 200	A200 The facility will ensure the patient's right to safe implementation of restraint and seclusion by trained staff. Each nurse and medical staff will be trained during employee orientation and on an annual basis regarding the safe implementation of restraints and seclusion. Training will include techniques in using non-physical intervention skills. The Director of Nursing will monitor and oversee training to ensure compliance.	11-14-08

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A 200	Continued From page 17 it should be implemented. The policy did address some nonphysical intervention skills. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 200		
A 201	482.13(f)(2)(iii) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition. This STANDARD is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to provide direct care staff and the medical staff with current training on choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition in their physical restraint training.. Findings include: Interview with the charge nurse on 9/23/08 regarding the use of restraints revealed that she	A 201	A201 The facility will ensure the patient's right to safe implementation of restraint and seclusion by trained staff. Each nurse and medical staff will be trained during employee orientation and on an annual basis regarding the safe implementation of restraints and seclusion. Training will include techniques of identifying and utilizing the least restrictive intervention for each individual patient. The Director of Nursing will monitor and oversee training to ensure compliance.	11-14-08

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A 201	Continued From page 19 Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 201		
A 202	482.13(f)(2)(iv) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (iv) The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia). This STANDARD is not met as evidenced by: Based on interviews and review of documentation, it was determined that the facility failed to provide direct care staff and the medical staff with current training on the use of physical restraints in orientation and on a reoccurring basis on the safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress. Findings include: Interview with the charge nurse on 9/23/08 regarding the use of restraints revealed that she had worked at the facility for a number of years.	A 202	A202 The facility will ensure the patient's right to safe implementation of restraint and seclusion by trained staff. Each nurse and medical staff will be trained during employee orientation and on an annual basis regarding the safe implementation of restraints and seclusion. Training will include techniques of the use of all types of restraint and seclusion used in the hospital, including training in how to recognize and respond to physical and psychological distress. The Director of Nursing will monitor and oversee the training to ensure compliance.	11-14-08

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A 202	Continued From page 21 Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 202		
A 204	482.13(f)(2)(v) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary. This STANDARD is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to provide direct care staff and the medical staff with current training on the use of physical restraints in orientation and on a reoccurring basis clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary. Findings include: Interview with the charge nurse on 9/23/08 regarding the use of restraints revealed that she had worked at the facility for a number of years. When asked about the use of restraints she stated that they did not use restraints on the acute floor but occasionally the use of restraints had been utilized in the Emergency Room to	A 204	A204 The facility will ensure the patient's right to safe implementation of restraint and seclusion by trained staff. Each nurse and medical staff will be trained during employee orientation and on an annual basis regarding the safe implementation of restraints and seclusion. Training will include techniques of identifying behavioral changes that indicate that the use of restraint or seclusion is no longer needed. The Director of Nursing will monitor and oversee the training to ensure compliance.	11-14-08

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A 204	Continued From page 23 policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 204		
A 205	482.13(f)(2)(vi) PATIENT RIGHTS: RESTRAINT OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (vi) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation. This STANDARD is not met as evidenced by: Based on interview and review of documentation, it was determined that the facility failed to provide direct care staff and the medical staff with current training on the use of physical restraints in orientation and on a reoccurring basis. Findings include: Interview with the charge nurse on 9/23/08 regarding the use of restraints revealed that she had worked at the facility for a number of years. When asked about the use of restraints she stated that they did not use restraints on the acute floor but occasionally the use of restraints had been utilized in the Emergency Room to protect the patient or staff. However she did agree that there may come a time when a restraint may be utilized on the acute floor for the same reason.	A 205	A205 The facility will ensure the patient's right to safe implementation of restraint and seclusion by trained staff. Each nurse and medical staff will be trained during employee orientation and on an annual basis regarding the safe implementation of restraints and seclusion. Training will include techniques of monitoring the patient's well being including respiratory, circulatory, skin integrity, vital signs during nursing evaluations and face-to-face evaluations within one hour by medical staff. The Director of Nursing will monitor and oversee the training to ensure compliance.	11-14-08

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A 206	Continued From page 25 OR SECLUSION [The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:] (vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification. This STANDARD is not met as evidenced by: Based on interview it was determined that the facility failed to ensure that all staff who apply, monitor, access or provide care for a patient in restraints has received training in the use of first aid techniques (Employee's #1 through #25). Findings Include: On 9/26/08 at 4:55 PM, the director of nurses (DON) was interviewed. He stated that not all of the clinical staff that applied, monitored, assessed or provided care for patients in restraints were trained in first aid. He identified the following employees as needing first aid training: Employee's #1 through #25.	A 206	A206 CPR training and certification is provided and will continue to be provided to direct care staff. First Aid training will be provided for direct care staff. CPR certification will be maintained and First Aid training specific to use of restraints will be required and provided on an annual basis. The Medical Director and/or the Director of Nursing will provide continued training and consultation. The Director of Nursing will monitor and oversee the training to ensure compliance.	11-14-08
A 207	482.13(f)(3) PATIENT RIGHTS: RESTRAINT OR SECLUSION Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors. This STANDARD is not met as evidenced by: Based on interviews and documentation review it was determined that the facility did not provide	A 207	A207 Training for the restraints will be performed by an individual that is qualified as evidenced by education, training, and experience in techniques to address patient behaviors. Immediate training will be provided by an audio/visual program that is professionally produced and qualified. The facility will continue to provide adequate and qualified training. The Director of Nursing will monitor and oversee the training to ensure compliance.	11-14-08

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A 207	Continued From page 27 the acute hospital's policy stated regarding the use of restraints. Review of the hospital's policy revealed the components of an accurate policy except for the reporting of death in restraints to CMS and when it should be implemented. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy. The Director of Nurses per interview on 9/23/08 stated that no one on the staff had the appropriate education, training and experience in techniques used to address patients' behaviors to give the training.	A 207		
A 208	482.13(f)(4) PATIENT RIGHTS: RESTRAINT OR SECLUSION Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed. This STANDARD is not met as evidenced by: Based on interview and review of documentation it was determined that the facility failed to provide direct care staff and the medical staff with current training on the use of physical restraints in orientation and on a reoccurring basis. Findings include:	A 208	A208 Copies of all care staff certifications and competencies will be kept in the personnel files by the Director of Human Resources. The Director of Nurses and the Director of Human Resources will monitor and assure compliance through annual personnel file audits.	11-14-08

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A 208	Continued From page 29 it should be implemented. Although the hospital was not accredited by The Joint Commission, the policy also made reference to The Joint Commission. It stated that the policy had been revised in 11/23/03 but there was no indication as to who approved the policy. The medical staff, the director of nursing, the risk manager, and the charge nurse were unaware of the hospital's policy. There were no documented competencies in the staff files on use of restraints in the acute care as outlined in the policy.	A 208		
A 264	482.21(a) QAPI PROGRAM SCOPE Standard: Program Scope This STANDARD is not met as evidenced by: Based on a review of the hospital Quality Improvement Program and an interview with the hospital's Quality Improvement (QI) representative, the hospital does not ensure that all hospital departments are included in the hospital-wide quality assessment and improvement program, by excluding the respiratory care department from the regular QI Report Schedule. Findings include: The hospital QI representative confirmed in an interview on 9/23/08 that the respiratory care department is not included in the regular QI Report Schedule for 2008. The QI Report Schedule for 2008 had twelve departments named and did not include the respiratory care department.	A 264	A264 Grover C. Dils Medical Center will ensure that each department is included in the facility Quality Assurance program. The Respiratory Care Department will be included in and accountable to the QI / Compliance Committee. All departments will be accountable to the QI / Compliance Committee for patient care statistics. The Risk Manager will monitor and assure compliance.	11-4-08
A 396	482.23(b)(4) NURSING CARE PLAN The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan	A 396		

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A 396	Continued From page 30 for each patient. This STANDARD is not met as evidenced by: Based on record review and interview it was determined that the facility failed to ensure that the nursing staff develops, and keeps current, a nursing care plan for 5 of 20 patients. (Patient #7, #11, #14, #17 and #18) Findings Include: Patient #7: The patient was admitted to the facility on 6/30/08 with a diagnosis of dehydration. The physician's progress note, dated 7/1/08, included a diagnosis of left eye conjunctivitis. No evidence was found of a nursing care plan in the patient's medical record. On 9/23/08 at 2:10 PM, the director of nurses (DON) was interviewed. He stated that the facility had identified problems with nursing care plans not being completed on the acute care side of the facility. The DON was asked if the care plan could be found in another section. The facility was not able to provide evidence that a nursing care plan had been developed for Patient #7. Patient's #14, #17 and #18 had no care plans in their medical records. This was confirmed by the Director of Nurses per fax copies and confirmation in the fax. Patient #11 had a goal but no care plan to implement the goal.	A 396	A396 The facility will ensure that the nursing staff develops, and keeps current a nursing care plan for each patient. Patients #7, #11, #14, #17, and #18 have been discharged. The facility will acquire a subscription to utilize CarePlans.com to assist in the development of personalized care plans for each patient. The Director of Nursing will monitor and assure compliance by performing monthly chart audits.	11-4-08
A 405	482.23(c)(1) ADMINISTRATION OF DRUGS All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable	A 405	A405 The facility will ensure that biologicals will be administered by, or under the supervision of, nursing or other personnel in accordance with Federal and State laws and regulations. Patient #7 was discharged. In-service training will be provided to each nursing staff of the current policy of "Medication-Brought into the hospital by patients." This in-service will be provided by the Director of Nursing. The Director of Nursing is responsible to monitor and assure compliance.	11-14-08

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A 405	Continued From page 32 Patient #7's eye drops were kept in the patient's drawer and the nurse had administered the eye drops. The facility's policy, titled, "Policy: Medication - Brought into the hospital by patients," revealed, "A patient's medications are never to be left at the bedside with the patient while they are hospitalized."	A 405		
A 432	482.24(a) ORGANIZATION AND STAFFING The organization of the medical record service must be appropriate to the scope and complexity of the services performed. The hospital must employ adequate personnel to ensure prompt completion, filing, and retrieval of records. This STANDARD is not met as evidenced by: Based on interview and review of the documentation it was determined that the facility's medical record department failed to have written policies and procedures in place to ensure prompt completion, filing and retrieval of records. Findings include: The medical record department was able to retrieve records easily when a random sample was selected. They had a computer software program that identified where the records were located. The head of medical records per interview on 9/25/08 was able to answer the question regarding requirements for length of time for storage, organization, necessary documentation in the medical record, HIPPA requirements and necessary time frames to be met to meet the state and federal requirements. When the head of medical records was asked	A 432	A432 The facility will ensure prompt completion, filing, and retrieval of records by reviewing, updating and approving policies and procedures that govern these activities. The Director of Business Services will monitor and assure compliance to this regulation.	11-4-08

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	290027	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVER C DILS MEDICAL CENTER	700 N SPRING ST, BOX 1010-C-ADM BLDG CALIENTE, NV 89008

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A 432	Continued From page 33 where their policies and procedures were kept, she could not locate the manuals. After approximately 30 minutes she provided the manuals. Review of the medical records policies documented that they had not been updated since 1991. The policies did not describe the current process being used to store medical records or any update of current state and federal requirements. The head of the medical records department confirmed the policies did not reflect current procedures in the department.	A 432		
A 450	482.24(c)(1) MEDICAL RECORD SERVICES All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. This STANDARD is not met as evidenced by: Based on interview and review of the documentation it was determined that the facility's medical record department failed to have written policies and procedures in place to ensure prompt completion, filing and retrieval of records. The facility failed to have a process in place to authenticate signatures. Findings include: The medical record department was able to retrieve records easily when a random sample was selected. They had a computer software program that identified where the records were located. The head of medical records per interview on 9/25/08 was able to answer the question regarding requirements for length of time for storage, organization, necessary	A 450	A450 The facility will ensure prompt completion, filing, and retrieval of records by reviewing, updating and approving policies and procedures that govern these activities. Specifically, the updated policy will detail a process to authenticate signatures. The Director of Business Services will monitor and assure compliance to this regulation. (See Attachment #3)	11-4-08

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A 450	Continued From page 34 documentation in the medical record, HIPPA requirements and necessary time frames to be met to meet the state and federal requirements. When the head of medical records was asked where their policies and procedures were kept, she could not locate the manuals. After approximately 30 minutes she provided the manuals. Review of the medical records policies documented that they had not been updated since 1991. The policies did not describe the current process being used to store medical records or any update of current state and federal requirements. The head of the medical records department confirmed the policies did not reflect current procedures in the department. There was no policy in place to authenticate signatures.	A 450		
A 500	482.25(b) DELIVERY OF DRUGS In order to provide patient safety, drugs and biologicals must be controlled and distributed in accordance with applicable standards of practice, consistent with Federal and State law. This STANDARD is not met as evidenced by: Based on interview it was determined that the facility failed to ensure the safe distribution of medications to inpatients in the facility. Findings Include: On 9/23/08 at 10:35 AM, the pharmacist technician was interviewed. She stated that the pharmacist came to the facility once a month. She stated that when the pharmacist was in the facility he reviewed medication orders for appropriateness before the first dose was dispensed. She stated	A 500	A500 It is the intention of Grover C. Dils Medical Center to comply with the regulations of 42 CFR 482.25(b). Due to the difficulty of finding 24/7 pharmacy coverage in our rural setting, Grover C. Dils Medical Center will obtain increased assistance from our consulting pharmacist. During normal work hours of 8am through 5pm (Mon.-Fri.) the consulting pharmacist will review all acute orders for appropriateness before dispensing. For orders that are written during other hours, the consulting pharmacist will review the orders for appropriateness within a 24-hour period. A back-up consultant will be pursued to aid and assist during times of vacation or emergency. The facility will continue the pursuit of 24/7 pharmacy coverage. To assist in the review by the pharmacist, the facility has provided remote access into the automated pharmacy system. The Director of Nursing and Administrator will monitor and assure compliance.	11-21-08

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A 500	Continued From page 35 that when the pharmacist was not in the facility there was no mechanism in place for the pharmacist to review medication orders for appropriateness before the first dose was dispensed to inpatients.	A 500		
A 536	482.26(b)(1) SAFETY FOR PATIENTS AND PERSONNEL Proper safety precautions must be maintained against radiation hazards. This includes adequate shielding for patients, personnel, and facilities, as well as appropriate storage, use and disposal of radioactive materials. This STANDARD is not met as evidenced by: Based on an observation of the radiology department, a review of radiology department policies, and an interview with radiology department personnel, the radiology department did not ensure that patient shielding was routinely checked. Findings include: It was confirmed by radiology department personnel that periodic checks of shielding for the ability to provide radiological safety to patients did not occur.	A 536	A536 The facility will ensure that proper safety precautions will be maintained against radiation hazards. A routine maintenance and inspection log will be kept by the radiology department, in which all shields and other patient and personnel safety equipment will be inspected. Any unsafe conditions will be reported to the Department Head and/or Administration for correction. The Administrator will monitor and assure compliance.	11-4-08
A 537	482.26(b)(2) PERIODIC EQUIPMENT MAINTENANCE Periodic inspection of equipment must be made and hazards identified must be promptly corrected. This STANDARD is not met as evidenced by: Based on a review of radiology department records and an interview with radiology department personnel on September 23, 2008,	A 537	A537 Grover C. Dils Medical Center will ensure periodic inspections of equipment. Hazards that are identified will be corrected. The facility will maintain documentation of all inspections and preventative maintenance that are performed on the radiological equipment. Written contracts and/or agreements will be secured to ensure continued maintenance. The Department Head and/or the Administrator will monitor and assure continued compliance.	11-21-08

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A 537	Continued From page 36 periodic inspection of the X-ray and MRI equipment was not made. Findings include: 1. Radiology personnel confirmed that no scheduled preventive maintenance had been performed on the X-ray instrument, the Quantum QT750, serial # QG40G03K1028, since its installation on November 24, 2003. 2. Radiology personnel confirmed that there was not a preventive maintenance contract for the MRI instrument, the Toshiba KCD-10M-7A, serial #B6592488.	A 537		
A 547	482.26(c)(2) QUALIFIED STAFF Only personnel designated as qualified by the medical staff may use the radiologic equipment and administer procedures. This STANDARD is not met as evidenced by: Based on a review of the hospital's Position Description for Radiologist Technologist, a review of hospital personnel records, and an interview with radiology department personnel on September 23, 2008, two of three radiology department personnel were not qualified to use radiologic equipment. Findings include: Among the qualifications listed in the hospital's Position Description for Radiology Technologist, "Must have academic training as a Radiologist Technologist" and "AART license preferred" are items A and B. 1. One previous employee of the department,	A 547	A547 Grover C. Dils Medical Center will ensure that only personnel designated as qualified by the medical staff may use the radiological equipment and administer procedures. The job description for Radiology Technologist will be reviewed and updated to reflect current qualifications for the Radiology Technologist Position. (See Attachment #10) The Medical Director will approve the changes to the job description. Each Radiology Technologist will be tested for competency and approved by the Medical Director on an annual basis. Competencies will be monitored and maintained in the personnel files. The Department Head and/or the Director of Human Resources will monitor and assure continued compliance through annual personnel file audits.	11-14-08

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A 547	Continued From page 37 who transferred from within the hospital on May 24 of 2007, did not have academic training in Radiology, and did not possess an American Registry of Radiologic Technologists license. 2. One current employee of the department, who transferred from within the hospital on June 23 of 2008, does not have academic training in Radiology, and does not possess an American of Radiologic Technologists license.	A 547		
A 592	482.27(b) POTENTIALLY INFECTIOUS BLOOD/BLOOD PRODUCTS Standard: Potentially infectious blood and blood products. (1) Potentially human immunodeficiency virus (HIV) infectious blood and blood components. Potentially HIV infectious blood and blood components are prior collections from a donor - (i) Who tested negative at the time of donation but tests reactive for evidence of HIV infection on a later donation; (ii) Who tests positive on the supplemental (additional, more specific) test or other follow-up testing required by FDA; and (iii) For whom the timing of seroconversion cannot be precisely estimated. (2) Potentially hepatitis C virus (HCV) infectious blood and blood components. Potentially HCV infectious blood and blood components are the blood and blood components identified in 21 CFR 610.47. (3) Services furnished by an outside blood collecting establishment. If a hospital regularly uses the services of an outside blood collecting establishment, it must have an agreement with	A 592	A592 The facility will ensure compliance to the regulations stated in 482.27(b). The facility Look-Back Policy and Procedures will be reviewed and updated to satisfy the new regulations in 482.27(b). The Director of Lab Services and the Medical Staff will approve changes. The facility will require the contracted blood collection organization to comply in policy to the regulations of 482.27(b). The Director of the Lab and the Lab Manager will monitor and assure compliance.	11-14-08

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A 592	Continued From page 42 resulting from donors tested before February 20, 2008 as set forth at 21 CFR 610.48 will expire on August 24, 2015. This STANDARD is not met as evidenced by: Based on a review of the laboratory's Look Back Procedure, reviewed by the laboratory director in April of 2008, and an interview with laboratory personnel on September 23, 2008, the laboratory failed to have in place a Look Back procedure which addressed each requirement of CFR 482.27(b), including updating the policy to include HCV where indicated. Findings include: The hospital laboratory Look Back procedure did not include all of the requirements of CFR 482.27(b), including: 1. Recipient notification to continue for 12 weeks 2. Recordingkeeping by the hospital 3. HCV testing, notification, counselling, etc. as indicated by the revisions to CFR 482.27(b) 4. Notification of relative or legal representative or guardian as needed or required 5. Steps to take when follow-up testing results are indeterminate	A 592		
A 620	482.28(a)(1) DIRECTOR OF DIETARY SERVICES The hospital must have a full-time employee who- (i) Serves as director of the food and dietetic services;	A 620	A620 Grover C. Dils Medical Center will ensure the employment of a full-time director of the food and dietetic services that is responsible for the daily management of dietary services and is qualified to perform these responsibilities. Patients #6, #7, #8, #16, and #19 were all discharged. A Full-Time Registered Dietician will be employed to direct the facility Dietary Services Department. The Registered Dietician will review, suggest, and monitor the individual dietary needs of all patients. Those in need of nutritional education will be referred to and assisted by the Registered Dietician. The Director of Dietary Services will monitor and assure compliance by performing monthly chart audits.	11-4-08

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A 620	Continued From page 46 There was no evidence found in Patient #7's record that a nutritional screening form was completed. There was no evidence found that the low albumin levels were evaluated to determine if the cause was over-hydration or malnutrition. Patient #8: The patient was admitted to the facility on 7/5/08 with diagnoses that included renal insufficiency, cirrhosis, diabetes, and anemia. The patient would be considered to be at high nutritional risk according to the facility's policy. There was no evidence found that a nutritional screening was completed or that the registered dietician completed an initial nutritional assessment and nutritional recommendations. The dietitian stated during a telephone interview on 9/23/08, in the afternoon, that she was used primarily for the skilled nursing facility residents. She stated that she had been involved in only one hospital patient case in the last three years. The Medical Director stated that if a dietician was available for the inpatients he was not aware of it. He stated he would like to see dietician services provided at the facility.	A 620		
A 621	482.28(a)(2) QUALIFIED DIETITIAN There must be a qualified dietitian, full-time, part-time, or on a consultant basis. This STANDARD is not met as evidenced by: Based on review of facility documents, staff interview and patient medical record review, it was determined the facility failed to have a dietitian providing nutrition and dietetic services to 20 of 20 acute care hospital patients.	A 621	A621 Grover C. Dils Medical Center will ensure that a qualified dietitian will be employed and accessible to provide the needed services for all acute patients. The Dietary Department will participate in the facility quality assurance and compliance program. The Administrator will monitor and assure compliance.	11-4-08

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A 621	Continued From page 47 Findings include: Review of the dietitian's contract revealed that the contract allowed for 6 hours every quarter for nutrition and dietetic services for the long term care unit (skilled nursing unit) but not the hospital. The dietitian stated during a telephone interview on 9/23/08 in the afternoon, that she did not provide in-service training for dietary staff, did not review or approve therapeutic menus or develop menus if needed, and did not provide discharge diet instruction, or nutritional assessments for hospital patients. She indicated during the interview that she would like to be involved with revising policies and procedures and diet instruction materials for patients. Her understanding of the services she was to provide, the terms of services in the current contract and allowable work hours did not include these services. There was no quality assurance plan for the dietary department related to the acute care hospital.	A 621		
A 622	482.28(a)(3) COMPETENT DIETARY STAFF There must be administrative and technical personnel competent in their respective duties. This STANDARD is not met as evidenced by: Based on observation it was determined that the facility staff failed to maintain the kitchen in a clean and sanitary manner. Findings include: There were three White Westinghouse reach-in	A 622	A622 The facility will ensure that dietary staff is competent through training in their respective duties. Three cited refrigerators will be replaced with new commercial refrigerators. Cited Conservator freezer will be properly cleaned. All food that was improperly stored was discarded. Proper freezer bag documentation was obtained. Burned out light bulbs were replaced. Staff will be in-serviced and trained in their respective duties. Including (A) the proper cleaning and maintenance of the kitchen and its equipment, (B) the proper labeling, dating and storage of food, and (C) the proper preparation of food. Training logs will be maintained by the Director of Dietary Services. The Director of Dietary Services will monitor and assure compliance by performing regular monitoring rounds and performing continued in-services.	11-21-08

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A 622	Continued From page 48 refrigerators that were not commercial grade and that had torn seals on the interior of the doors. One carton of heavy whipping cream in the middle refrigerator had an expiration date of 9/4/08. The reach-in "Conservator" freezer was in need of cleaning due to a build-up of food debris on the interior of the unit. One bag of hash browns was not re-sealed completely after opening or dated. There were multiple food products stored in plastic bags purchased from "Sysop". There was no documentation available to verify the plastic bags were food grade safe and appropriate for freezing food items. There were burned out light bulbs in the dry food storage room. The following food items were not resealed completely after being opened: one bag of spaghetti noodles, cake mix, banana pudding mix, sugar free butterscotch pudding, vanilla instant pudding mix and cornbread mix. One package of instant pudding mix had been opened and resealed but was not dated. Bread crumbs were being stored in a non NSF approved food grade storage container. One employee was consuming a soft drink beverage in the kitchen during food preparation.	A 622		
A 628	482.28(b) DIETS Menus must meet the needs of the patients. This STANDARD is not met as evidenced by: Based on review of the facility menus, the facility did not ensure the menus were approved by the dietitian or meet the needs of the patients. Findings include:	A 628	A628 Grover C. Dils Medical Center will ensure that menus meet the needs of the patients. New menus and therapeutic manuals will be obtained that will be approved by the Dietician and Medical Director. The Director of Dietary Services will monitor and assure compliance.	11-4-08

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A 628	Continued From page 49 The menus were from Crandall and Associates and were dated 2002. There was no documentation to verify the dietitian approved the menus as nutritionally adequate for the hospital patients.	A 628		
A 631	482.28(b)(3) THERAPEUTIC DIET MANUAL A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel. This STANDARD is not met as evidenced by: Based on review of facility documentation the facility failed to have a current therapeutic diet manual available for staff. Findings include: Review of the "Contemporary Nutrition and Diet Handbook" provided by facility staff revealed that the medical staff and dietitian did not review or approve the use of this handbook as the therapeutic diet manual. The handbook was last revised in 2004.	A 631	A631 Grover C. Dils Medical Center will ensure that menus meet the needs of the patients. New menus and therapeutic manuals will be obtained that will be approved by the Dietician and Medical Director. The Director of Dietary Services will monitor and assure compliance.	11-4-08
A 747	482.42 INFECTION CONTROL The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases. This CONDITION is not met as evidenced by: Based on observation, interview and documentation review, the facility failed to have an active program for the prevention, control, and	A 747		

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A 747	Continued From page 50 investigation of infections and communicable diseases for patients. Findings include: The following processes were not in place as evidence by: CFR 482.42(a) (A 0748) The infection control officer was not qualified by education or training to perform the duties of an infection control officer. CFR 482.42(a)(1) (A 0749) No active surveillance system was in place for infections and communicable diseases that occurred in the facility for patients. CFR 482.42(a)(2) (A 0750) No log of incidents related to infections and communicable disease was maintained by the facility.	A 747	A747 Grover C. Dils Medical Center will provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. A comprehensive Infection Control Program will be implemented to satisfy the regulations of CFR 482.42. A 748-- An Infection Control Officer will be named in writing. This person will be qualified or actively seeking the qualifications and education necessary. The Administrator will monitor and assure compliance to this regulation. A 749-- As part of the Infection Control Program, an active surveillance system will be implemented to monitor infections and communicable diseases that occur in the facility. The Infection Control Officer will monitor and assure compliance by presenting data during monthly Infection Control Meetings. A 750-- As part of the Infection Control Program, a log of incidents related to infections and communicable disease will be maintained. The Infection Control Officer will monitor and assure compliance by presenting data during monthly Infection Control Meetings.	11-14-08
A 748	482.42(a) INFECTION CONTROL OFFICER(S) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on interview and personnel record review it was determined that the facility failed to designate in writing an infection control officer that was qualified through education and/or training. Findings Include: On 9/23/08 at 9:30 AM, the director of nurses (DON) was interviewed. He stated that he also served as the facility's infection control officer. He stated that he did not have specialized training in infection control; he did not have any certifications in infection control and his	A 748		

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A 748	Continued From page 51 experience was not in infection control. The DON's personnel file was reviewed. There was no evidence found in the DON's personnel file which revealed that he had specialized training or certification in infection control.	A 748	A748 Grover C. Dils Medical Center will provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. A comprehensive Infection Control Program will be implemented to satisfy the regulations of CFR 482.42. An Infection Control Officer will be named in writing. This person will be qualified or actively seeking the qualifications and education necessary. The Administrator will monitor and assure compliance.	11-14-08
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on interview it was determined that the facility failed to develop a system for identifying, investigating and controlling infections of patients in the facility. Findings Include: On 9/24/08 at 11:50 AM, the director of nurses (DON) was interviewed. The DON also served as the facility's infection control officer. The DON was asked how infection control surveillance was being conducted at the facility for patients. He stated that patient cultures were in the system and that he was going to devise a log for cultures but it had not been implemented yet. He was asked how he would be able to determine if positive cultures were a result of a hospital acquired infection. He did not have a system in place to determine this. The facility had a policy titled, "Infection Control Surveillance." The policy revealed, "Surveillance of microorganisms shown on cultures: Although this is not a good indicator of the number of infections in the facility, review and analysis of culture sensitivities may serve as	A 749		

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A 749	Continued From page 52 an alert to a problem (e.g., multiresistant organisms, cross-contamination). There was no evidence found that the data from the cultures was being reviewed and analyzed. The DON/infection control officer did not have an active surveillance program in place for patients and was not following the facility's infection control surveillance policy. On 9/22/08 observations were made of sterile packages, ready for patient use, processed at the facility. One chest tube tray was observed with dried water marks on the package. Two sterile peel packs with a sterilized instrument in each pack were observed to have dried water marks on the packages. Three suture sets were observed to have dried water marks on the package. The Association for the Advancement of Medical Instrumentation (AAMI) Sterilization in Health Care Facilities manual, 2006-2007 Edition, revealed that items removed from sterilizers should be visually inspected and that packages that appear to be wet should not be used. The AAMI manual revealed, "Items with torn or wet packaging are considered contaminated. Wet packaging might indicate problems with package composition, loading procedures, sterilizer performance or operation, or the steam generation and distribution system." On 9/22/08 observations were made that internal chemical indicators (CI) were not observed in all of the peel packs with sterilized instruments in them. The outer packages of the peel packs had an indicator. The AAMI manual revealed "An internal CI should be used within each package, tray, or rigid sterilization container system to be sterilized." "Internal CIs should be used in the	A 749	A749 Grover C. Dils Medical Center will provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. A comprehensive Infection Control Program will be implemented to satisfy the regulations of CFR 482.42. A log of patient cultures has been implemented to determine if positive cultures were the result of a hospital-acquired infection. All sterile packages with watermarks were removed and reprocessed. The drying process was corrected by properly setting the drying cycle. All sterile packages will be marked with a lot #, date and initials of the operator. The laryngoscope was reprocessed according to manufactures specifications. All dirty instruments will be decontaminated and processed in the dirty room before they enter the sterile cleaning room. A cleaning and maintenance log will be kept to ensure continued cleaning and maintenance of the autoclave. All cleaning solutions have been properly labeled. A) New policies and procedures for the sterilization process have been approved and implemented. (See Attachment #4) B) Training of applicable staff will be performed and necessary certifications for a Sterilization Technician will be actively pursued.	11-14-08

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A 749	Continued From page 53 routine monitoring of items sterilized." On 9/23/08 observations were made that not all sterile packages were labeled with a lot number, date and initial of the person who processed the sterile package. The facility did not maintain a log of the loads run, the dates the loads were run, the lot numbers of the loads run, the specific contents of the loads run and the initials of the operator. The AAMI manual revealed, "For each sterilization cycle the following information should be recorded and maintained: a) the lot number b) the specific contents of the lot or load, including quantity, department, and a specific description of the items (e.g. towel packs, type/name of instrument sets): c) The exposure time and temperature, if not provided on there sterilizer recording chart d) the name or initials of the operator e) the results of biological testing, if applicable g) the response of the CI placed in the PCD ... h) any reports of inconclusive or nonresponsive CI's found later in the load" "Rationale: Documentation ensures that the sterilization process is monitored as it is occurring, ensures that cycle parameters have been met, and establishes accountability. In addition, documentation helps personnel determine whether a recall is necessary should evidence subsequent to lot release, such as a positive BI (biological indicator) or nonresponsive CI (chemical indicator), suggest sterility problems. Knowing the contents of the lot or load enables personnel to identify the medical devices to be recalled." "In addition, this documentation provides evidence of the department's quality control program."	A 749	C) All cleaning solutions will be properly labeled and EPA approved. In-services will be provided by the Director of Environmental Services to applicable staff regarding the proper use and storage of cleaning solutions. D) A cleaning and maintenance log will be kept for the autoclave. E) During routine rounds, the Infection Control Officer will inspect and remove out-dated supplies. The Director of Nursing and the Infection Control Officer will monitor and assure compliance.	

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A 749	Continued From page 58 (4) outdated trays on the bottom of trays that were not outdated. Staff failed to rotate stock to ensure that outdated supplies were not available for use on patients.	A 749	A750 Grover C. Dils Medical Center will provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. A comprehensive Infection Control Program will be implemented to satisfy the regulations of CFR 482.42. As part of the Infection Control Program, an active surveillance system will be implemented to monitor infections and communicable diseases that occur in the facility. A log of incidents related to infections and communicable disease will be maintained. Collected data will be presented during monthly Infection Control Meetings. The Infection Control Officer will monitor and assure compliance.	11-14-08
A 750	482.42(a)(2) INFECTION CONTROL LOG The infection control officer or officers must maintain a log of incidents related to infections and communicable diseases. This STANDARD is not met as evidenced by: Based on interview it was determined that the facility failed to maintain a log of incidents related to infections and communicable diseases. Findings Include: On 9/24/08 the director of nursing (DON) was interviewed. He stated that he also acted as the facility's infection control officer. He stated that the facility did not maintain a log of incidents related to infections and communicable diseases.	A 750		
A 800	482.43(a) CRITERIA FOR DISCHARGE EVALUATIONS The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. This STANDARD is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to identify for 1 of 20 patients the need for adequate discharge planning to address psychiatric needs. (Patient #17) Findings include:	A 800		

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A 800	Continued From page 59 Patient #17: The patient was admitted on 6/11/08 with a documented diagnosis of "intentional overdose, suicidal ideations, anxiety". It was stated throughout the physicians documentation that the patient would not sign a suicide contract until the day he was discharge. There was no documentation that the patient had been referred to psychological services or that the physician had discussed his case with the patient's previous psychiatrist. No discharge documentation was found addressing psychiatric services referral or psychiatric followup for the patient. Patient #17 was readmitted on 6/25/08 to the emergency room. The diagnosis was "cutting throat, attempted suicide". As result of this visit to the emergency room the attending physician had flown him to another major hospital to obtain psychiatric services. During an interview with the risk manager who also worked as a charge nurse on the floor regarding this case, she stated she was aware of this case. She stated that the community had no resources. However, further investigation revealed that there was a mental health clinic that was serviced by the State Mental Health system that was open in the community on a regular basis each month on specified days. Review of the medical record also revealed that the attending physician had recommended a social services consult to obtain a referral for disability. Interview with the social worker on 9/24/08 it was stated that she had done the disability referral. However, when the social worker was asked if she had asked the physician or the patient about a psychiatric referral or follow-up she stated she had not.	A 800	A800 Grover C. Dils Medical Center will ensure that adequate discharge planning will be performed for patients likely to suffer adverse health consequences upon discharge. Patient #17 was discharged from the facility. The Director of Social Services will review acute patient files daily to assist in the discharge planning for each acute patient. A list of referral sources with phone numbers will be established and posted at the nurse's station. If a discharge occurs during a weekend, the Director of Social Services will be involved as needed. The Director of Social Services and/or the Director of Nursing will review and audit charts monthly to monitor and assure compliance. The needed referrals will be pursued to promote continued care. Psychiatric care services will be pursued by the Administrator.	11-4-08

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A 800	Continued From page 60 No discharge planning was documented on the first admission to refer this patient to psychiatric services to possibly prevent a readmission for attempted suicide.	A 800		
A 884	482.45 ORGAN, TISSUE, EYE PROCUREMENT Organ, Tissue and Eye Procurement This CONDITION is not met as evidenced by: Based on interview it was determined that the facility failed to ensure that specific organ, tissue, and eye procurement requirements were met. Findings Include: There was no contract or collaboration with an organ procurement organization to ensure that specific organ, tissue and eye procurements requirements were met.	A 884	A884 Grover C. Dils Medical Center will ensure that the specific requirements pertaining to organ, tissue and eye procurement are met. The facility will secure a contract/agreement with Nevada Donor Network, Inc. to function as the facility organ procurement organization. (See Attachment #5) The Administrator will monitor and assure compliance to this regulation.	11-4-08
A 885	482.45(a) WRITTEN POLICIES AND PROCEDURES The hospital must have and implement written protocols that: This STANDARD is not met as evidenced by: Based on interview it was determined that the facility failed to implement the facility's organ procurement policy. Findings Include: On 9/25/08, the charge nurse and a registered nurse were interviewed regarding the facility's organ procurement policy. They stated that the organ procurement organization (OPO) was to far away and would not come to the facility. The charge nurse also stated that there was no	A 885	A885 Grover C. Dils Medical Center will ensure that the specific requirements pertaining to organ, tissue and eye procurement are met. The facility will review and update the Organ Procurement Policy and Procedure to reflect the agreement with Nevada Donor Network, Inc. The Medical Director and/or the Governing Board will approve the policy. (See Attachment #6) The Administrator will monitor and assure compliance.	11-4-08

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A 885	Continued From page 61 refrigerator available at the hospital for organ procurements. She did not mention keeping the patient on a ventilator until the OPO arrived. On 9/25/08, the administrator stated he had found an OPO that would come to the facility. The facility's policy on organ procurement revealed, "Federal law requires that all deaths be reported to the local organ procurement organization. If a patient is a potential organ donor (neurologically insulted and on a ventilator), federal law requires that the organ procurement organization be called when death is imminent." "Why is a ventilator important to organ transplantation? In order to keep donated organs functioning before transplantation, a ventilator must be in use. Organs deteriorate rapidly once death occurs; if the patient is not on a ventilator the organs will not be usable for transplantation."	A 885		
A 886	482.45(a)(1) OPO AGREEMENT Incorporate an agreement with an OPO designated under part 486 of this chapter, under which it must notify, in a timely manner, the OPO or a third party designated by the OPO of individuals whose death is imminent or who have died in the hospital. The OPO determines medical suitability for organ donation and, in the absence of alternative arrangements by the hospital, the OPO determines medical suitability for tissue and eye donation, using the definition of potential tissue and eye donor and the notification protocol developed in consultation with the tissue and eye banks identified by the hospital for this purpose; This STANDARD is not met as evidenced by: Based on interview it was determined that the	A 886	A886 Grover C. Dils Medical Center will ensure that the specific requirements pertaining to organ, tissue and eye procurement are met. The facility will review and update the Organ Procurement Policy and Procedure to reflect the agreement with Nevada Donor Network, Inc. Notification to the OPO will be implemented according to the policy and procedures. Data from monthly chart audits will be presented to the QI / Compliance Committee. The Administrator will monitor and assure compliance.	11-14-08

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A 886	Continued From page 62 facility failed to have a written agreement with an Organ Procurement Organization. Findings Include: On 9/25/08 at 1:50 PM, the administrator stated the facility did not have a contract with an Organ Procurement Organization.	A 886		
A 888	482.45(a)(3) INFORMED FAMILY Ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its options to donate organs, tissues, or eyes, or to decline to donate. This STANDARD is not met as evidenced by: Based on interview it was determined that the facility failed to ensure, in collaboration with the organ procurement organization, that the family of each potential donor was informed of its options to donate organs, tissues, or eyes, or to decline to donate. Findings Include: On 9/25/08 at 1:50 PM, the administrator stated the facility did not have a contract with an Organ Procurement Organization (OPO). On 9/25/08, the charge nurse and a registered nurse were interviewed regarding the facility's organ procurement policy. They stated that the OPOs are too far away and would not come to the facility. The charge nurse also stated that there was no refrigerator available at the hospital for organ procurements. She did not mention keeping the patient on a ventilator until the OPO arrived.	A 888	A888 Grover C. Dils Medical Center will ensure that the specific requirements pertaining to organ, tissue and eye procurement are met. The facility will review and update the Organ Procurement Policy and Procedure to reflect the agreement with Nevada Donor Network, Inc. Grover C. Dils Medical Center will work in cooperation with the OPO to inform families of their donation options. Notification to the OPO and family will be implemented according to the policy and procedures. An in-service will be provided by the OPO on November 14, 2008. Data from monthly chart audits will be presented to the QI / Compliance Committee. The Administrator will monitor and assure compliance.	11-14-08

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A 888	Continued From page 63 On 9/25/08, the administrator stated he had found an OPO that would come to the facility. There was no evidence found that the facility worked in collaboration with the OPO to ensure that the family of each potential donor was informed of its options to donate organs or to decline to donate.	A 888		
A 889	482.45(a)(3) DESIGNATED REQUESTOR The individual designated by the hospital to initiate the request to the family must be an organ procurement representative or a designated requestor. A designated requestor is an individual who has completed a course offered or approved by the OPO and designed in conjunction with the tissue and eye bank community in the methodology for approaching potential donor families and requesting organ or tissue donation. This STANDARD is not met as evidenced by: Based on interview and document review it was determined that the facility failed to have a process in place to initiate the request for organ or tissue donation to the family. Findings Include: On 9/25/08 at 1:50 PM, the administrator stated the facility did not have a contract with an Organ Procurement Organization (OPO). On 9/25/08, the charge nurse and a registered nurse were interviewed regarding the facility's organ procurement policy. They stated that the OPOs are too far away and would not come to the facility. The charge nurse also stated that there was no refrigerator available at the hospital	A 889	A889 Grover C. Dils Medical Center will ensure that the specific requirements pertaining to organ, tissue and eye procurement are met. The facility review and update the Organ Procurement Policy and Procedure to reflect the agreement with Nevada Donor Network, Inc. As agreed upon between OPO and facility, a designated person or representative will initiate the request to the family for organ procurement. Training will be performed by the OPO on 11-14-2008. The Administrator will monitor and assure compliance.	11-14-08

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A 889	Continued From page 64 for organ procurements. She did not mention keeping the patient on a ventilator until the OPO arrived. On 9/25/08, the administrator stated he had found an OPO that would come to the facility.	A 889		
A1101	482.55(a) ORGANIZATION AND DIRECTION Organization and Direction. If emergency services are provided at the hospital -- This STANDARD is not met as evidenced by: Based on observation and interview it was determined that the facility failed to ensure the emergency room was supplied with necessary supplies to ensure the safety of pediatric patients. Findings Include: On 9/22/08 at 5:35 PM, there were no pediatric defibrillator pads observed in the emergency room. On 9/25/08 at 3:35 PM, the director of nurses confirmed that there were no pediatric defibrillator pads in the emergency room. He stated that they were on back order.	A1101	A1101 The facility will ensure that the needed supplies and resources are available in the emergency room. Pediatric defibrillator pads have been purchased and stocked for future use. In-services will be provided to the materials manager and other appropriate staff to ensure prompt resolution to ordering difficulties. The Finance Controller will monitor and assure compliance by checking the log of back ordered items. (See Attachment #7)	11-14-08
A1152	482.57(a) ORGANIZATION OF RESPIRATORY CARE SERVICES The organization of the respiratory care services must be appropriate to the scope and complexity of the services offered. This STANDARD is not met as evidenced by: Based on a review of the Grover C. Dils Acute Care Policies and Procedures manual, an interview with the respiratory therapist, and an interview with the hospital CEO, the scope and	A1152		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A1152	Continued From page 65 complexity of the respiratory services offered has not been defined in writing, and therefore it cannot be determined if the services provided are adequate and if the services provided are within the acceptable standards of practice. Findings include: There is no evidence that the gamut of respiratory services provided by the hospital is in writing. The respiratory therapist provided a verbal list of the services provided by the hospital. There is no evidence that the services provided are offered in accordance with the acceptable standards of practice, except for the individual licenses and certifications held by the respiratory therapist and the other healthcare providers who perform and assist with intubation and ventilator management for codes, oxygen services, breathing treatments, the pulse-oximeter, blood gases, and pulmonary function studies.	A1152	A1152 Grover C. Dils Medical Center will ensure the appropriate organization and structure of the Respiratory Care Department according to the scope and complexity of the services provided. Policies and procedures will be established that clearly define the department's purpose, leadership, employee qualifications, and the scope and complexity of the services. (See Attachment #8) The Administrator will monitor and assure compliance.	11-4-08
A1153	482.57(a)(1) DIRECTOR OF RESPIRATORY SERVICES There must be a director of respiratory care services who is a doctor of medicine or osteopathy with the knowledge, experience and capabilities to supervise and administer the service properly. The director may serve on either a full-time or part-time basis. This STANDARD is not met as evidenced by: Based on an interview with the respiratory therapist and a review of hospital policies, the medical director duties and the medical director's personnel file, the hospital does not have a director of respiratory care services who is qualified to oversee the department.	A1153	A1153 The facility will ensure that the director of the Respiratory Care Department is a doctor of medicine or osteopathy with knowledge, experience and capabilities to supervise and administer the service properly. A document will be prepared stating that the Administrator and the Medical Director feel that the Medical Director is qualified to direct the Respiratory Care Services Department. (See Attachment #9) The Administrator will monitor and assure compliance.	11-4-08

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	290027	A. BUILDING _____ B. WING _____	09/25/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GROVER C DILS MEDICAL CENTER	700 N SPRING ST, BOX 1010-C-ADM BLDG CALIENTE, NV 89008

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A1153	Continued From page 66 Findings include: 1. There was no evidence of a hospital organizational chart which defined and named a director of the respiratory care department. 2. The medical director of the hospital, who serves in the role of the director of respiratory services, does not have the education or experience to function in this role. 3. There is no evidence that the medical director has participated in the oversight of the department.	A1153		
A1160	482.57(b) RESPIRATORY CARE SERVICES POLICIES Services must be delivered in accordance with medical staff directives. This STANDARD is not met as evidenced by: Based on a review of the Grover C. Dils Medical Center Acute Care Policies and Procedures manual provided for the surveyor by the Director of Nursing, an interview with the respiratory therapist, and an interview with the hospital CEO, there exists no documentation that the respiratory services provided by the hospital have been approved by the medical staff. Findings include: Hospital staff were unable to provide for the surveyor a comprehensive list of the respiratory services provided by the hospital which had been approved by the medical staff.	A1160	A1160 Grover C. Dils Medical Center will ensure that the services of the Respiratory Care Department will be delivered in accordance with Medical Staff Directives. The Respiratory Care Department Policies and Procedures clearly define a director of the respiratory care department including a list of the respiratory services that are provided and who is approved and qualified to perform the services. Respiratory Care Policies and Procedures will show approval from the medical staff for the following: Intubation/Ventilator Management in the emergency room will only be performed by those practitioners with documented competency, with approval and under the supervision of the medical director. Acute patients requiring intubation and or ventilator management will be transported to appropriate or higher level of care. Oxygen services provided by nasal cannula, simple and re-breather mask, medication administration by nebulizer will be performed by nursing personnel within their scope of practice with a practitioner order. Arterial Blood Gas samples will be obtained by qualified registered nurses or laboratory technicians and processed by laboratory technicians. The Director of Respiratory Care Services will monitor and assure compliance. Collected data from this department will be reported during QI / Compliance Committee Meetings.	11-14-08
A1161	482.57(b)(1) RESPIRATORY CARE PERSONNEL POLICIES	A1161		

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A1161	Continued From page 67 Personnel qualified to perform specific procedures and the amount of supervision required for personnel to carry out specific procedures must be designated in writing. This STANDARD is not met as evidenced by: Based on a review of the personnel file of the respiratory therapist, a review of the Grover C. Dils Medical Center Acute Care Policies and Procedures manual, and an interview with the respiratory therapist, the personnel qualified to perform specific procedures and the amount of supervision required to do so was not designated in writing. Findings include: 1. A list of respiratory procedures provided by the hospital was not available, and therefore, except for the positive and non-positive pressure breathing aerosol therapy procedures found in the hospital's acute care procedure manual and the blood gas procedures offered by the laboratory, a list of those personnel qualified to perform specific procedures and their supervision requirements was not designated in writing.	A1161	A1161 Grover C. Dils Medical Center will ensure that the services of the Respiratory Care Department will be delivered in accordance with Medical Staff Directives. The Respiratory Care Department Policies and Procedures clearly define a director of the respiratory care department including a list of the respiratory services that are provided and who is approved and qualified to perform the services. Respiratory Care Policies and Procedures will show approval from the medical staff for the following: Intubation/Ventilator Management in the emergency room will only be performed by those practitioners with documented competency, with approval and under the supervision of the medical director. Acute patients requiring intubation and or ventilator management will be transported to appropriate or higher level of care. Oxygen services provided by nasal cannula, simple and re-breather mask, medication administration by nebulizer will be performed by nursing personnel within their scope of practice with a practitioner order. Arterial Blood Gas samples will be obtained by qualified registered nurses or laboratory technicians and processed by laboratory technicians. The Director of Respiratory Care Services will monitor and assure compliance. Collected data from this department will be reported during QI / Compliance Committee Meetings	11-14-08

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